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7  
8 **BEFORE THE**  
**BOARD OF REGISTERED NURSING**  
9 **DEPARTMENT OF CONSUMER AFFAIRS**  
**STATE OF CALIFORNIA**

10  
11 In the Matter of the Accusation Against:

Case No. **2010-530**  
**ACCUSATION**

12 **ALISON MARY HANSEN**  
16945 Roberts Road # 23  
13 Los Gatos, CA 95032

14 **Registered Nurse License No. RN 510443**

15 Respondent.

16  
17 Complainant alleges:

18 **PARTIES**

19 1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her  
20 official capacity as the Interim Executive Officer of the Board of Registered Nursing, Department  
21 of Consumer Affairs.

22 2. On or about April 6, 1995, the Board of Registered Nursing issued Registered Nurse  
23 License Number RN 510443 to Alison Mary Hansen (Respondent). The Registered Nurse  
24 License was in full force and effect at all times relevant to the charges brought herein and will  
25 expire on March 31, 2011, unless renewed.

26 **JURISDICTION**

27 3. This Accusation is brought before the Board of Registered Nursing (Board),  
28 Department of Consumer Affairs, under the authority of the following laws. All section

1 references are to the Business and Professions Code unless otherwise indicated.

2 4. Section 2750 of the Business and Professions Code ("Code") provides, in pertinent  
3 part, that the Board may discipline any licensee, including a licensee holding a temporary or an  
4 inactive license, for any reason provided in Article 3 (commencing with section 2750) of the  
5 Nursing Practice Act.

6 5. Section 2761 of the Code states:

7 "The board may take disciplinary action against a certified or licensed nurse or deny an  
8 application for a certificate or license for any of the following:

9 "(a) Unprofessional conduct, which includes, but is not limited to, the following:

10 "(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing  
11 functions.

12 ..."

13 6. Section 2762 of the Code states:

14 "In addition to other acts constituting unprofessional conduct within the meaning of this  
15 chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this  
16 chapter to do any of the following:

17 "(a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed  
18 physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or  
19 administer to another, any controlled substance as defined in Division 10 (commencing with  
20 Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as  
21 defined in Section 4022.

22 "(b) Use any controlled substance as defined in Division 10 (commencing with Section  
23 11000) of the Health and Safety Code, or any dangerous drug or dangerous device as defined in  
24 Section 4022, or alcoholic beverages, to an extent or in a manner dangerous or injurious to  
25 himself or herself, any other person, or the public or to the extent that such use impairs his or her  
26 ability to conduct with safety to the public the practice authorized by his or her license.

27 "(c) Be convicted of a criminal offense involving the prescription, consumption, or  
28 self-administration of any of the substances described in subdivisions (a) and (b) of this section,

1 or the possession of, or falsification of a record pertaining to, the substances described in  
2 subdivision (a) of this section, in which event the record of the conviction is conclusive evidence  
3 thereof.

4 "(d) Be committed or confined by a court of competent jurisdiction for intemperate use of  
5 or addiction to the use of any of the substances described in subdivisions (a) and (b) of this  
6 section, in which event the court order of commitment or confinement is prima facie evidence of  
7 such commitment or confinement.

8 "(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any  
9 hospital, patient, or other record pertaining to the substances described in subdivision (a) of this  
10 section."

11 7. Section 2764 of the Code provides, in pertinent part, that the expiration of a license  
12 shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the  
13 licensee or to render a decision imposing discipline on the license.

14 8. Section 118, subdivision (b), of the Code provides that the expiration of a license  
15 shall not deprive the Board of jurisdiction to proceed with a disciplinary action during the period  
16 within which the license may be renewed, restored, reissued or reinstated.

17 9. Section 125.3 of the Code provides, in pertinent part, that the Board may request the  
18 administrative law judge to direct a licensee found to have committed a violation or violations of  
19 the licensing act to pay a sum not to exceed the reasonable costs of the investigation and  
20 enforcement of the case.

## 21 DRUGS

22 10. Vicodin and Norco are brand names for compounds of varying dosages of  
23 acetaminophen and hydrocodone bitartrate, a Schedule III controlled substance as designated by  
24 Health and Safety Code section 11056(e)(4) and a dangerous drug as designated by Business and  
25 Professions Code section 4022, used for pain relief. These drugs come in different strengths such  
26 as 5/325 (5 mg acetaminophen and 325 mg of hydrocodone bitartrate) and 10/325.

27 11. Percocet is the brand name for oxycodone, a Schedule II controlled substance as  
28 designated by Health and Safety Code section 11055(b)(1)(n) and a dangerous drug as designated

1 by Business and Professions Code section 4022, used for pain relief.

2 FIRST CAUSE FOR DISCIPLINE

3 (ILLEGALLY OBTAIN OR POSSESS CONTROLLED SUBSTANCES)

4 12. Respondent is subject to disciplinary action under Code section 2761(a) on the  
5 grounds of unprofessional conduct, as defined by Code section 2762(a), in that while on duty as a  
6 registered nurse at Community Hospital of Los Gatos, Los Gatos, California, Respondent illegally  
7 obtained and/or possessed controlled substances as follows:

8 Patient 1:

9 a. On September 30, 2007, the patient's physician ordered one tablet of Vicodin every  
10 four hours as needed for mild pain, and two tablets every four hours as needed for moderate to  
11 severe pain. On October 1, 2007 at 18:44, Respondent removed two Vicodin from the hospital  
12 Pyxis<sup>1</sup>, and at 22:42, Respondent removed one Vicodin from the Pyxis. Respondent documented  
13 administration of one Vicodin at 18:40 and one at 22:30 (both before the medication was  
14 withdrawn); however, there was no documentation of the remaining one Vicodin being  
15 administered, nor was there documentation of wastage.

16 Patient 2:

17 b. On November 3, 2007, the patient's physician ordered one tablet of Vicodin every  
18 four hours as needed for moderate to severe pain. On November 4, 2007 at 20:45, Respondent  
19 removed two Vicodin from the hospital Pyxis. Respondent documented administration of one  
20 Vicodin at 20:45; however, there was no documentation of the remaining one Vicodin being  
21 administered, nor was there documentation of wastage.

22 Patient 3:

23 c. On November 11, 2007, the patient's physician ordered one tablet of Percocet every  
24 four hours as needed for pain. On November 13, 2007 at 18:01 and again at 21:05, Respondent  
25 removed two Percocet from the hospital Pyxis. Respondent documented administration of one  
26

27 \_\_\_\_\_  
28 <sup>1</sup> Pyxis is a hospital computerized medication storage system.

1 Percocet at 21:00; however, there was no documentation of the remaining three Percocet being  
2 administered, nor was there documentation of wastage.

3 Patient 4:

4 d. On November 14, 2007, the patient's physician ordered one tablet of 5/325 Norco  
5 every three hours as needed for pain. On November 22, 2007 at 16:02, Respondent removed two  
6 10/325 Norco from the hospital Pyxis, and at 19:36 Respondent removed one 10/325 Norco from  
7 the Pyxis. Respondent documented administration of one 10/325 Norco at 17:45; however, there  
8 was no documentation of the remaining two 10/325 Norco being administered, nor was there  
9 documentation of wastage.

10 Patient 5:

11 e. On November 27, 2007 at 16:42 and again at 22:52, Respondent removed two  
12 Percocet from the hospital Pyxis. Respondent documented administration of one Percocet at  
13 16:30 and another Percocet at 22:45 (before the medications were withdrawn); however, there  
14 was no documentation of the remaining two Percocet being administered, nor was there  
15 documentation of wastage.

16 Patient 6:

17 f. On November 25, 2007, the patient's physician ordered one tablet of Vicodin every  
18 four hours routinely, one tablet every four hours as needed for moderate to severe pain, or two  
19 tablets every four hours as needed for severe pain. On November 27, 2007 at 18:02 and again at  
20 21:36, Respondent removed two Vicodin from the hospital Pyxis. Respondent documented  
21 administration of one Vicodin at 18:00 and one Vicodin at 22:00; however, there was no  
22 documentation of the remaining two Vicodin being administered, nor was there documentation of  
23 wastage.

24 g. On November 30, 2007 at 18:05, Respondent removed one Vicodin from the hospital  
25 Pyxis. At 22:21, Respondent removed two Vicodin from the Pyxis. Respondent documented  
26 administration of one Vicodin at 18:00 and one Vicodin at 22:00; however, there was no  
27 documentation of the remaining one Vicodin being administered, nor was there documentation of  
28 wastage.

1 Patient 7:

2 h. On November 27, 2007, the patient's physician ordered one tablet of Percocet every  
3 three hours as needed for pain. On November 30, 2007 at 15:57, 20:07, and again at 22:28,  
4 Respondent removed one Percocet from the hospital Pyxis. Respondent documented  
5 administration of one Percocet at 16:00 and again at 22:00; however, there was no documentation  
6 of the remaining one Percocet being administered, nor was there documentation of wastage.

7 Patient 8:

8 i. On November 14, 2007, the patient's physician ordered one tablet of Percocet every  
9 four hours as needed for mild pain, and two tablets as needed every four hours. On December 1,  
10 2007 at 17:20, 17:51, and again at 20:33, Respondent removed one Percocet from the hospital  
11 Pyxis. Respondent documented administration of one Percocet at 17:45 and again at 20:15;  
12 however, there was no documentation of the remaining one Percocet being administered, nor was  
13 there documentation of wastage.

14 SECOND CAUSE FOR DISCIPLINE

15 (ILLEGAL USE OF CONTROLLED SUBSTANCES)

16 13. Respondent is subject to disciplinary action under Code section 2761(a) on the  
17 grounds of unprofessional conduct, as defined by Code section 2762(b), in that between October  
18 1, 2007 and December 1, 2007, at Community Hospital of Los Gatos, Los Gatos, California,  
19 Respondent used Vicodin, Norco and Percocet, controlled substances, to an extent or in a manner  
20 dangerous or injurious to herself and/or others.

21 THIRD CAUSE FOR DISCIPLINE

22 (FALSIFY, OR MAKE GROSSLY INCORRECT, GROSSLY INCONSISTENT, OR  
23 UNINTELLIGIBLE ENTRIES IN ANY PATIENT RECORD)

24 14. Respondent is subject to disciplinary action under Code section 2761(a) on the  
25 grounds of unprofessional conduct, as defined by Code section 2762(e), in that while on duty as a  
26 registered nurse at Community Hospital of Los Gatos, Los Gatos, California, Respondent  
27 falsified, made grossly incorrect, grossly inconsistent, or unintelligible entries in hospital and  
28 patient records, as alleged above in paragraphs 12.a. through 12.i.

1 FOURTH CAUSE FOR DISCIPLINE

2 (GROSS NEGLIGENCE)

3 15. Respondent is subject to disciplinary action under section 2761(a) in that she  
4 committed gross negligence as alleged above in paragraphs 12.a. through 12.i., 13 and 14.

5 FIFTH CAUSE FOR DISCIPLINE

6 (UNPROFESSIONAL CONDUCT)

7 16. Respondent is subject to disciplinary action under section 2761(a) in that she acted  
8 unprofessionally as alleged above in paragraphs 12.a. through 12.i., 13 and 14.

9  
10 PRAYER

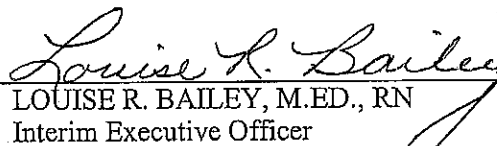
11 WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged,  
12 and that following the hearing, the Board of Registered Nursing issue a decision:

13 1. Revoking or suspending Registered Nurse License Number RN 510443, issued to  
14 Alison Mary Hansen.

15 2. Ordering Alison Mary Hansen to pay the Board of Registered Nursing the reasonable  
16 costs of the investigation and enforcement of this case, pursuant to Business and Professions  
17 Code section 125.3.

18 3. Taking such other and further action as deemed necessary and proper.  
19  
20

21 DATED: 4/21/10

  
LOUISE R. BAILEY, M.ED., RN  
Interim Executive Officer  
Board of Registered Nursing  
Department of Consumer Affairs  
State of California  
Complainant

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